Public Comment regarding CCIP:

I applaud the work of the Practice Transformation Task Force in researching and developing the CCIP report. It reflects a recognition of the best evidence and practice nationally and grounds it with a respectfulness for the local needs of community.

All in the health and health care community recognize that the majority of what drives health outcomes lies outside the clinical setting. While it is necessary to improve clinical practice continually, there are very real limits on practices ability to eliminate the health inequities that this state faces. If where one lives, plays, and works are divorced from clinical care, the ability to change a pattern of racial and ethnic health disparities in Connecticut is severely limited.

As the SIM plan was being developed, the constant refrain we heard whether it was a provider, patient, or family was that the system is not a system but fragmented parts pieced together with the burden for navigation placed families. CCIP is a concrete step toward bridging community and clinical care as seen in the import placed on care transitions and a comprehensive care team including Community Health Workers (CHW).

Considerations/Feedback:

- The three design principles: whole person centered care, health information availability to all, and accountability are sound and should be used to evaluate the components of the plan to see if standards collectively will achieve these principles. I would suggest some way of noting that in the next iteration.
- Data is critical, and collection and stratification of race, ethnicity, and language must be required of networks and/or FQHCS or efforts will be in vain. I would suggest that this be explicitly stated as part of the RFP.
- The separation in the development of the Medicaid Shared Savings effort and CCIP is unfortunate. It makes it more difficult seeing CCIP as a critical distinguishing factor in achieving the health outcome improvement that can result in shared savings. CCIP's added design is critical in making this RFP about outcomes versus clinical measures and process improvement. The parallel tracks can make seeing the whole design and intent more challenging and makes it appear as an add on versus how real improvement and savings can be achieved. Whatever can be done in the next month to bridge this gap will reap benefit for the state.
- CCIP can be an experiment that takes us to the bridge needed between community and clinical care, and I agree that it should be implemented for all patients regardless of payment source, but how does this actually happen without incentives of some form from payers? The RFP must secure both advanced networks and FQHCs otherwise it can default into a "Medicaid only" program.
- The three target populations are those most in need: complex patients, patients experiencing health equity gaps with particular attention to race and ethnicity, and behavioral health.
- The emphasis on diabetes, asthma, and hypertension is an absolute priority and reflect the goals of the SIM. Alignment is critical, and the draft acknowledges the need for this alignment. Given this, limiting the choices of networks and practices on targeting inequities to those in plan would be most productive such as the three identified.
- The articulation of the role and need for CHWs as part of the team and a critical means of improving care transitions and connection to community is excellent. As we develop a vision of

population health and the means to achieve it, the certification and recognition of CHWs is a high priority. How are we making that happen?

- Shared analytics and real time data are essential to achieving objectives which leaves the question of how are we supporting this capacity versus wishing it were so?
- Technical Assistance is critical in order to build capacity and support the required system design work necessary, but the likelihood of participation and success will be greatly enhanced with other incentive dollars or rewards. These do not have to be substantial, but they can make a difference. The SIM budget should be revisited to account for this.
- Is what is outlined standards or a blueprint on how to accomplish these objectives? It reads as a blueprint which is fine, but if standards, I did not see what are baseline standards that must be met. Given that this is a design with TA as the primary support, I wonder if standards is the right term. If it is then, how linked to payment model or shared savings. This needs more development or clarity.
- Community Health Board concept understandable and problematic. It is not natural or organic so will face significant challenges and questions as to its legitimacy. Is there something from which to build in a community. What support is this board going to receive so it can function effectively. This concept needs more thought and development; otherwise, can be seen as an interloper.

Again, this is a very strong and thoughtful draft. I particularly appreciate the references and concrete examples of what works such as Camden and Hennepin County. (Note Minnesota uses Medicaid dollars to pay CHWs.) This draft identifies the right priorities, design principles, and provides key steps to developing the community clinical connection required if CT is to achieve the goals articulated in the State Innovation Model and transform care for the purpose of improving health outcomes. It needs further development regarding baseline requirements and accountability.

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